

## MASSAGE THERAPY ESTABLISHMENT APPLICATION INSTRUCTION SHEET

Enclosed is the application packet for the massage therapy establishment registration. Included in the packet is the application, a copy of the Massage Therapy Act, and the Department of Health Rules.

PRINT or TYPE all information on the application. Please answer all questions completely, do not leave any blank. The application fee must be paid by personal check, cashiers check or money order. No cash.

To expedite processing, make sure the application is complete. If you do not receive a response within five weeks, call (512) 834-6616.

**Send completed application and related documentation with your fee to:**

Texas Department of Health  
Massage Therapy Registration Program  
P.O. Box 12197  
Austin, Texas 78711-2197

**Requests regarding the status of your application or other information should be sent to:**

Texas Department of Health  
Massage Therapy Registration Program  
1100 West 49th Street  
Austin, Texas 78756-3183  
512/834-6616  
massage@tdh.state.tx.us

**APPLICATION CHECK LIST:**

**BE SURE TO:**

- C Read the Massage Therapy Act (Texas Occupations Code, Chapter 455) and the Rules relating to massage therapy registration (Texas Administrative Code, Chapter 141) before completing application.
- C Attach the \$155.00 application fee (guaranteed funds only)
- C Answer all questions have been answered and all blanks filled in.
- C Attach a signed and notarized affidavit.
- C Attach a floor plan of establishment.
- C Attach the Fire Marshall's inspection report or letter.

**NOTE: No massage establishment can commence operation until the application for registration of the establishment has been approved. In addition, an establishment may employ only registered massage therapists to perform massage therapy. The current establishment registration certificate along with the current registration certificate(s) of all therapists must be displayed in a prominent location available for inspection by the public.**

## MASSAGE THERAPY ESTABLISHMENT APPLICATION

**Type or print legibly. Incomplete applications will not be processed. Attach the \$155.00 application fee to the upper left hand corner of this page. Send personal check, cashiers check or money order only. No cash. Failure to do so may delay processing. Use N/A for not applicable.**

1. Legal Name of Establishment \_\_\_\_\_

2. Address of Establishment \_\_\_\_\_  
(Street )

\_\_\_\_\_  
(City) (County) (State) (Zip)

3. Mailing Address of Establishment \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (County) (State) (Zip)

4. Telephone Number of Establishment (\_\_\_\_\_) \_\_\_\_\_

5. List All Massage Therapists Who Are Working With This Establishment:  
(Attach additional pages as necessary).

<u><b>Name</b></u>	<u><b>Social Security Number</b></u>	<u><b>MT Registration Number</b></u>
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6. List all personnel who exercise operational and/or managerial control over the operations of the establishment, or if they directly or indirectly control the day-to-day operations of the establishment.

<u><b>Name</b></u>	<u><b>Title</b></u>	<u><b>Address</b></u>	<u><b>%Owned</b></u>
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7. Describe the type of available or proposed facilities and services.


8. Attach a current inspection report of the local Fire Marshall. If an inspection is not required by the County or City, a letter from the County Attorney or City Official must be submitted.

9. Attach a photocopy of the valid sales tax permit issued to the massage establishment, if applicable.

10. Attach a floor plan of the proposed massage establishment that includes a sketch of the following items:

Entrance and exits;  
Length and width of establishment (in feet);  
Total square feet;  
Location of restroom(s); and  
Number of massage tables.

Evidence of separation from the establishment of rooms used wholly or in part for residential or sleeping purposes by a solid wall or by a wall with a solid door which shall remain locked during business hours. (Section 141.51(c)).

11. Proposed opening date: \_\_\_\_\_

12. Has any owner or operator been convicted of a felony or misdemeanor?  
**G Yes G No**

Has any owner or operator ever entered a plea of nolo contendere, entered a plea of guilty, or received deferred adjudication for a felony or misdemeanor?  
**G Yes G No**

If you answered yes to either of the above, provide the following information and documents for all felony and/or misdemeanor offenses (not minor traffic violations). Include any convictions which are currently on appeal. Attach additional information/documentation if appropriate.

Indicate offense(s) committed \_\_\_\_\_  
Date(s) of conviction(s) \_\_\_\_\_  
City, County, and State where offense(s) committed \_\_\_\_\_  
List other names you have used (e.g. married/maiden, etc) \_\_\_\_\_  
Are/were you on probation/parole? **G Yes G No** If YES, discharge date \_\_\_\_\_

**Submit copies of charging documents (referred to as indictment or information) and judgement or other documents showing disposition of the case(s). If still on parole/probation, submit letter from parole or probation officer indicating compliance with all parole or probationary conditions.**

**NOTE: Failure to report convictions may result in denial of the application or revocation of registration.**

13. Under local law is the establishment required to register as a sexually oriented business?  
**G YES G NO** If yes, you must enclose a copy of the local license and applicable rules/ordinances.

**Refer to: Texas Occupations Code Title 3, Section 455.155(d) AA sexually oriented business may not: (1) register under this chapter; or (2) operate as a massage establishment under this chapter.**

14. Check the Type of Ownership and complete the appropriate section.

**G Individual G Partnership G Corporation**

Indicate your federal I.D. Number \_\_\_\_\_ (Issued by Internal Revenue Service)

## INDIVIDUAL

- (a) Name of owning individual \_\_\_\_\_  
(b) Address of owner \_\_\_\_\_  
(c) Telephone No. Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

## PARTNERSHIP

- (a) Name of owning partnership \_\_\_\_\_  
(b) Registered address of partnership place of business \_\_\_\_\_  
(c) Telephone Number of partnership place of business ( ) \_\_\_\_\_  
(d) List names of all partners and percentage of ownership

Name	% Owned
_____	_____
_____	_____
_____	_____

## CORPORATE OWNERSHIP

- (a) Name of owning corporation \_\_\_\_\_  
(b) Registered address of corporation \_\_\_\_\_  
(c) Telephone number of corporation \_\_\_\_\_  
(d) List all officers, directors and registered agents of the corporation. (Use additional sheet, if necessary, and identify as Attachment A). List each shareholder owning stock aggregating at least 35% of the total issued and outstanding shares. Subsidiary corporations should list the parent corporation as stockholders

Name	Title	Address	% Owned
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- (e) Corporate Franchise Tax: Check one if owner is a corporation:

- G Franchise Tax is Current  
G Franchise Tax is Not Current  
G Corporation is exempt  
G Out-of-State Corporation - not subject to Texas tax

## **AFFIDAVIT**

This form shall be executed and submitted by **each** of the following:

- C In the case of an individual, that individual;
- C In the case of ownership by a partnership, each partner;
- C In the case of ownership by a profit corporation, each shareholder of the corporation owning at least 35% of the total issued and outstanding shares, each director, and each officer;
- C In the case of ownership by a non-profit corporation, each director or officer of the corporation must complete this form.
- C Disclosure of a social security number by an applicant is mandatory under the Family Code, Section 231.302 and the Health Insurance Portability and Accountability Act of 1996, Section 221. Social Security numbers are confidential and will be used for identification and reporting purposes required by law.

**You may reproduce this form as many times as needed.**

\_\_\_\_\_  
(Establishment Name)

\_\_\_\_\_  
(Establishment Address)

Name \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

\_\_\_\_\_  
Sex 9Male 9 Female Date of Birth \_\_\_\_\_  
Social Security Number mm/dd/yy

Position Or Title \_\_\_\_\_

Business Address \_\_\_\_\_  
Street City County State Zip

Home Address \_\_\_\_\_  
Street City County State Zip

\_\_\_\_\_  
Work Phone No.

\_\_\_\_\_  
Home Phone No.

**Answer the following questions. If a question does not apply, enter ANot Applicable®. Do not leave any space blank.**

1. List all other states in which you have operated an establishment.
2. List all massage establishments in which you have held an ownership interest of 35% or by which you have been employed in any capacity whether in or out of this state.
3. If you have ever had a diploma, credential, license or certificate of any kind denied, revoked, or suspended, or if you have been employed by an establishment whose credential, license, or certification has been denied, revoked, or suspended, please state the facts here.
4. If you have ever been convicted of a felony or a misdemeanor other than a minor traffic offense, please state the date, court, offense, and punishment.

**AFFIDAVIT**

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_, WHERE  
WITNESSED. THE INDIVIDUALS NAMED BELOW, BEING DULY SWORN, DEPOSE AND SAY THAT  
THE INFORMATION IN THIS APPLICATION, ACCOMPANYING ESTABLISHMENT INFORMATION,  
SUPPLEMENTS, ADDENDA, EXHIBITS, AND MATERIALS ARE TRUE AND CORRECT TO THE BEST  
OF THEIR KNOWLEDGE AND BELIEF. FURTHER, THE ESTABLISHMENT WILL BE OPERATED IN  
COMPLIANCE WITH THIS APPLICATION AND ALL LEGAL REQUIREMENTS. ANY DEFICIENCIES  
WILL BE IMMEDIATELY CORRECTED AND CHANGES IN THE OPERATION WILL NOT BE MADE  
UNTIL WRITTEN APPROVAL FROM THE TEXAS DEPARTMENT OF HEALTH IS RECEIVED, IF  
REQUIRED BY THE RULES.

Signature of each individual owner, each partner if a partnership, or each director if a corporation (if  
applicant is another type of business entity, the Texas Department of Health shall identify signatures  
needed). Use additional pages, if necessary, for signatures.

_____ (Signature)	_____ (Typed Name and Title)
_____ (Signature)	_____ (Typed Name and Title)
_____ (Signature)	_____ (Typed Name and Title)

SUBSCRIBED AND SWORN TO BEFORE ME THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_.

MY COMMISSION EXPIRES \_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

SEAL